

MDR Tracking Number: M5-04-0339-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on October 3, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor \$450** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic procedures, application modal, and unlisted procedures were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 11/11/02 through 01/16/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 2<sup>nd</sup> day of January 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PNR/pnr

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

December 19, 2003

**Re: IRO Case # M5-04-0339**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient suffered multiple injuries to the right upper extremity. The documentation provided for this review does not detail the exact nature of the injuries, but concern treatment after a radial head replacement. Evidently, the patient had a radial head replacement and physical therapy from 11/11/02 through 1/6/03.

The documentation provided in the treating physician's office notes as well as letters of medical necessity and physical therapy documentation demonstrate objective evidence of slow improvement and improved range of motion in the patient.

Requested Service(s)

Therapeutic procedures, application modal, unlisted proc 11/11/02-1/16/03

Decision

I disagree with the carrier's decision to deny the requested treatment.

Rational

Although the initial utilization review physician did not have adequate documentation at the time of his review, the documentation that is now provided adequately documents significant functional impairment in this patient and a good response to occupational therapy. Based on the complexity of the patient's injuries and the surgery that he received, I disagree with the opinion that the physical therapy "could be performed as a home exercise program." The provided documentation justifies ongoing occupational therapy due to the increase in the patient's functional status, strength and range of motion while at the same time decreasing his pain. During the period of disputed therapy, the patient's flexion increased from 90 degrees to 125 degrees.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.